

DBHS Practice Protocol

Clinical Supervision



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
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Title:

Clinical Supervision

Goal/What Do We Want to Achieve Through the Use of this Protocol?:

The goal of this Practice Protocol is to ensure the appropriate frequency and content of clinical supervision at the Tribal/Regional Behavioral Health Authority (T/RBHA) and Provider levels, and to avoid the tendency to substitute administrative supervision for clinical supervision. By stressing the importance and content of good clinical supervision, it is also the goal of this protocol to increase the behavioral health professional's ability to provide quality and consistent care from the first point of contact throughout the continuum of care by:

- Enhancing the supervisee's personal and professional development (skills/knowledge/profession attitude)
- Providing regular supervision grounded in best practices
- Assessing and evaluating supervisee competence and effectiveness on a regular basis
- Adhering to agency, licensing, and accrediting requirements
- Monitoring legal, ethical, and cultural issues
- Ensuring staff retention and overall welfare.

The application of this protocol is broad in nature with the intent that all direct care staff, regardless of education, licensure, or certification are receiving regular, quality, clinical supervision appropriate to the service tasks for which they are responsible. This protocol is also intended as an enhancement, not a replacement, to the specific guidelines for the frequency and broad content areas of clinical supervision set down in [Arizona Administrative Code R9-20-205](#) as well as expectations established for clinical supervisors in [Arizona Administrative Code R4-6-212](#). The unique issues of those seeking or maintaining licensure or certification in a specific discipline are not directly addressed within this protocol.

Target Audience:

This protocol is directed to those practitioners at the T/RBHA and their subcontracted Network and Provider agencies who are ultimately responsible for the supervision, monitoring, evaluating, and/or training of all direct care staff.

Target Population(s):

All behavioral health direct care providers receiving supervision.

Definitions:

Clinical Supervision is an intervention by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and enhances the professional functioning, monitors service quality, and acts as a gate-keeping process for those who are entering the profession (Bernard and Goodyear, 2004).

Administrative Supervision, on the other hand, is concerned with the correct, effective, and appropriate implementation of agency policies and procedures. The supervisor has been given authority by the agency to oversee the work of the supervisee. The primary goal is to ensure adherence to policy and procedure (Kadushin 1992)

Background:

Although clinical supervision is a distinct professional competency, standards and training have been substantially neglected in that most clinicians have not had formal training in clinical supervision (Scott, Ingram, Vitanza, & Smith, 2000). Providing skilled and effective clinical supervision extends beyond the skill set required when providing therapeutic services to behavioral health recipients. In other words, being a good clinician does not automatically mean being a good clinical supervisor.

The Florida Institute for Continuing Professional Development states that clinical supervision is a formal process of professional support which provides a means of encouraging self-assessment and the development of analytical and reflective skills. It is a practice-focused professional relationship that enables the supervisee to develop knowledge and competence, and to reflect on his/her clinical work with the support of a skilled supervisor.

Clinical Supervision is also a process that facilitates the evaluation of a supervisee's interactions with a consumer to ensure the best quality of care is provided. It is a dynamic, collaborative process which includes the components of teaching and mentorship and aims to enable the supervisee to develop, achieve, and sustain a high quality of practice. This process provides an opportunity for regular protected time for facilitated, in-depth reflection on clinical practice and professional issues. This reflective practice translates into improvements in the supervisee's practice. Clinical Supervision both empowers and supports those in practice and should continue throughout the clinician's career.

Front line clinicians and their supervisors report that clinical supervision has been compromised by financial, regulatory, and administrative demands on service programs. This has resulted from redundant accountabilities to federal, state, county, city, and private regulatory bodies that produce an exponential growth in standards and monitoring visits. Clinical directors and supervisors report that pockets of high quality clinical supervision continue to flourish, but that they now represent the exception. (White and Schwartz, 2007).

Due to the many expectations placed on clinicians and their supervisors, formal clinical supervision has, in many cases, been limited to a brief case review, data validation, or a focus on "problem" or critical/emergency issues. This tension between clinical and administrative supervision can make regular, quality supervision of all direct care staff more an exception than the rule. The clinical supervisor is continually challenged to maintain a proper balance between the growth of the supervisee and the effectiveness of the organization.

Finally, the lack of consistent, focused supervision can lead to low staff morale, high staff turnover, and reduced quality care. In this sense, the lack of quality clinical supervision can reduce the amount of direct care (and billable) hours available to consumers even more than the hours invested in solid clinical supervision. In other words, the time spent in best practice driven, clinical supervision can potentially increase the quality and effectiveness of consumer contact hours, consumer retention, clinician retention and wellbeing, and the overall quality of care to service recipients.

A study by DeStefano et al. (2003) highlighted this last point. They surveyed 848 rural Arizona professional and paraprofessional clinicians in the Northern Arizona Behavioral Health Authority (NARBHA) and the two service areas now served by Cenpatico Behavioral Health of Arizona. The survey results indicated higher than normal levels of burnout and job dissatisfaction. They found that "those surveyed were less satisfied with all aspects of supervision including their relationship with their clinical supervisor." Respondents reported that they did not trust in their supervisor's competency in helping them make important decisions. In addition, the study found that 31.2% of respondents scored in the medium or high range for all three sub-scales in the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1996) and reported significantly higher levels of Emotional Exhaustion than the normed group.

Finally, 42% of the 132 participants that agreed to a structured interview in addition to the survey reported that high stress would or might possibly cause them to leave their present jobs.

In addition to recommending improved training and orientation of new staff, the authors suggested that key to responding to the high burnout and job dissatisfaction of those surveyed would be improved clinical supervision. They recommended that this supervision include skill building in case conceptualization, in treatment planning, and in developing treatment strategies. They further pointed out that too often clinical supervision was “hit or miss” and rarely regular. As a result of that information, they strongly recommended that both the quality and quantity of supervision had to improve. Their recommendations included formalized training of new clinical supervisors at the RBHA level to include ethical and legal issues as well as models of clinical supervision.

The study found that regular, quality clinical supervision conducted by specially trained clinical supervisors is one of the top contributors to high job satisfaction, job longevity, and the overall emotional well-being of direct care staff. The addition of regular, quality, clinical supervision hours will actually increase productivity and quality of care rather than detract from or hinder it.

Recommended Processes and Procedures:

Enhancing the supervisee's personal and professional development:

Quality clinical supervision builds on the skills training that direct care staff receive. However, clinical supervisors should encourage supervisees to go beyond required trainings and seek out opportunities to build on existing skills as well as expand their fund of knowledge in their respective areas of responsibility.

While clinical supervision focuses on professional skills development, it also emphasizes growth in self-awareness and understanding on the part of supervisees. Direct care staff face a number of challenges to their professional abilities but often more so to their personal well-being. Large case loads, crisis situations, budget constraints can take their toll on supervisees. As a result, clinical supervisors should monitor signs of “burn-out” and job dissatisfaction so that any related concerns may be detected and addressed early on. Guiding the supervisee in greater self-awareness and self-care can increase the overall well-being of the clinician and, in turn, the quality of care to service recipients.

Because supervisees respond to the needs of a wide variety of populations on a large continuum of need, clinical supervisors also must be aware of, trained in, and able to direct supervisees in a number of specific areas, most especially those within the scope of work of the supervisee. Therefore, personal and professional development is also the responsibility of the clinical supervisor as well.

Providing regular supervision grounded in best practices:

Best practices in behavioral health services address the fact that all direct care staff should be receiving consistent, substantive supervision. In other words, clinical supervision done on a regular basis for a length of time that will allow for focus on both a review and discussion of the supervisee's cases as well as discussion and evaluation of the supervisee's skills and self-awareness. While some supervisees have specific supervision requirements mandated by state statute and/or professional license or certification, other supervisees may not have such requirements. It is especially important that those direct care staff without specific, mandated supervision still receive the benefits of regular, substantive supervision.

The clinical supervisor should first of all establish a safe, private environment for supervision with clear expectations and processes. In the supervision process, the supervisor should:

- Explore and clarify the critical thinking skills of the supervisee by giving them practice in case conceptualization
- Foster the supervisee's intuitive skills by guiding them to look beyond words and objective materials
- Train and supervise the proper and ethical use of assessment tools and procedures
- Maintain clear professional boundaries between supervisor and supervisee also teaching proper boundaries between supervisees and service recipients
- Provide clear, specific, objective feedback on both strengths and weaknesses of supervisee skills
- Discuss conflict with supervisees when it occurs
- Respect human diversity and individual differences that may exist between the supervisor and supervisee providing safe venue for the discussion of those differences
- Share information, experience, and skills from his/her own professional practice
- Ensure that supervisees remain within their level of training and competency
- Confront personal and professional blocks to growth and self-awareness of supervisees including behaviors and conditions that may cause impairment
- Be aware of organizational contracts, policies, procedures, which the supervisee must follow
- Keep records of supervision which include the cases, skills, and possible concerns discussed
- Be aware of the different models of clinical supervision that reflect the differing professional training and expectations, work contexts, and needs of staff
- Be knowledgeable of the [National Board of Certified Counselors' Approved Clinical Supervisor \(ACS\) Code of Ethics](#) as well as those ethical codes which guide the supervisee

Assessing and evaluating supervisee competence and effectiveness on a regular basis:

A major role of clinical supervision is to ensure that the supervisee's professional competence is equal to the responsibilities and unique expectations of their respective jobs. When it is determined that the supervisee needs to improve certain competencies, it is the responsibility of the clinical supervisor to point out the areas that need improvement and assist/direct the supervisee in taking appropriate steps to remediate those skills. When reviewing cases, guidance should be provided to the supervisee in the process of case conceptualization – seeing the bigger picture rather than focusing too narrowly on specific diagnostic criteria. Understanding the needs and challenges of the whole person provides a more appropriate framework for effective service planning and case management.

This understanding is also essential for consumer retention, satisfaction, and successful service planning. Supervisees are to be guided in developing the broader, foundational skills of consumer engagement and rapport building, and involving consumers in their service planning process. They should also identify and incorporate the consumer's personal goals, strengths, expectations, cultural uniqueness, and past experiences into service planning. These basic supervisee competencies are essential to effective consumer service.

Clinical supervisors should also strongly encourage their supervisees to briefly survey consumers at the end of each engagement to evaluate their level of effectiveness with the consumer. This will also gauge whether or not the consumer feels part of the process and is likely to continue. There are a number of formal and informal instruments available for this purpose and applicable to a number of different levels of training and licensure. Clinical supervisors and their supervisees should explore available tools that evaluate the working alliance between clinician and recipient and use these tools on a regular basis.

Adhering to agency, licensing, and accrediting requirements:

Clinical supervisors are responsible to see that supervisees are aware of the practice expectations of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). These expectations include, but are not limited to, the "[Arizona Vision and 12 Principles](#)," the special needs of

children, the Developmentally Disabled, substance use disorders, as well as appropriate state statutes, and applicable ethical and legal issues. Clinicians/supervisees should have a general, working knowledge of the [ADHS/DBHS Provider Manual](#) and applicable [Clinical Practice Protocols](#), as well as a basic understanding of the Psychosocial Rehabilitation Model. Finally, and very importantly, both clinical supervisors and their supervisees should have a solid grasp of the concepts of recovery and resiliency as they apply to human service provision; understanding that these are not part of, but rather the core of best practice in the field.

Monitoring legal, ethical, and cultural competency issues:

Early detection of any ethical or legal issues that may be involved as well as the dynamics of transference, counter-transference, and maintaining appropriate boundaries are also essential skills to be developed and fostered early on in the supervisory relationship. Clinical supervisors need to ensure that supervisees have a working knowledge of the [Arizona Administrative Code R-9-20](#) and [R-9-21](#) as it applies to their specific responsibilities. In addition, clinical supervisors should ensure that supervisees:

- have a knowledge and understanding of their respective licensing/accrediting body's code of ethics where applicable
- initiate and organize their own personal and professional practice development
- are accountable for their own work and inform the supervisor of any difficulties
- identify specific practice issues for discussion and improvement
- are open to receiving and integrating feedback in their practice
- are sensitive to and make effort to respond to specific cultural needs of the consumer and the unique context of each consumer
- understand that culture is defined broadly and includes issues of gender, sexual orientation, spirituality, and economics

Ensuring staff retention and overall welfare:

Not only are clinical supervisors responsible for ongoing training, skills enhancement, and professional growth, they must also monitor and teach supervisees to self-monitor in the areas of burnout, compassion fatigue, and impairment. Pearlman and Mac Ian (1995) note that one of the ten best ways to guard against burnout and impairment is regular, quality clinical supervision. Helping supervisees to grow in their self-awareness, as well as monitoring for signs of emotional stress and potential impairment can enable the supervisor to take early supportive action.

In addition to the lack of regular clinical supervision some factors that can threaten supervisee wellness and competence include, but are not limited to:

- the nature of the service recipients (e.g. vulnerable children, complexity of problems, safety concerns)
- the nature of the workplace (e.g. insufficient resources or vacation time, lack of input into the decision-making process of the organization, current policies that may prohibit best practice treatment)
- training, education and experience, current stressors, and/or changes in life outside of work, natural coping style, a personal history of trauma, and beliefs that limit the likelihood to seek support (Catherall, 1995; Cerney, 1995; Saakvitne, Pearlman & Mac Ian, 1996).

The [American Counseling Association's \(ACA\)](#) Task Force on Impaired Counselors has examined a number of self-assessment instruments designed to identify vulnerabilities to impairment. Two instruments in particular seem to be especially helpful in identifying areas of vulnerability across the many spheres of wellness with which counselors should be concerned. [The Professional Quality of Life \(ProQOL-III\)](#) assessment measures compassion fatigue, compassion satisfaction, vicarious traumatization, and potential for burnout in counselors (Stamm, 2002). As a balance to the ProQOL-III the task force also

recommends the [Self-Care Assessment](#) (Saakvitne, Pearlman & Staff of TSI/CAAP, 1996). This assessment focuses on the wellness activities in which counselors may participate across several domains of wellness (physical, psychological, spiritual, and professional).

Training and Supervision Recommendations

This Practice Protocol applies to T/RBHAs and their subcontracted network and provider agencies for all who provide clinical supervision to all direct care staff. Each T/RBHA shall establish their own process for providing training and guidance to those who provide clinical supervision to ensure they have current knowledge and skill, up to date information, and awareness of best practices in clinical supervision.

A number of national professional organizations provide guidelines and best practices in clinical supervision of their practitioners. A number of companies who provide continuing education units (CEUs) nationwide offer workshops as well as online courses specifically designed for clinical supervisors. T/RBHAs should strongly encourage clinical supervisors to attend/participate in regular training that specifically addresses clinical supervision theories and practice as well as training in best practices in their respective fields and the service areas of those whom they supervise.

Finally, clinical supervisors are also expected to be knowledgeable regarding the [ADHS/DBHS Provider Manual Section 9.1 Training Requirements](#) to insure that their supervisees are in compliance.

Anticipated Outcomes:

It is anticipated that by maintaining regular, quality, clinical supervision sessions with direct care staff (supervisees), the following outcomes will be realized:

- Supervisees will experience growth in self-awareness, as well as skill and knowledge base
- Supervisees will be aware of and trained in best practices in their respective areas of service
- Supervisees will be regularly evaluated and given feedback on professional competency
- Supervisees will be better aware of agency, licensing, ethical, and state requirements
- Supervisees will experience greater work satisfaction, health, and employment longevity
- Supervisees will provide more effective, high quality service to recipients

Desktop Guide

Key Elements to remember about this best practice:

- Clinical supervision is distinct from administrative supervision
- Clinical supervision includes attention to both professional and personal growth
- High quality clinical supervision often represents the exception rather than the norm
- There is a need for better training and clearer standards for clinical supervision
- Clinical supervisors need to be highly skilled in the areas of practice of their supervisees
- Clinical supervisors should continually update their skills and knowledge in supervision
- Consistent clinical supervision promotes staff retention and wellbeing as well as quality of care delivered to consumers

Benefits of using this best practice:

- Greater work satisfaction, retention, and well being of direct care staff
- Greater self-awareness and skill building for supervisees
- Better monitoring of quality of care to consumers
- Greater adherence to legal, ethical, and cultural issues
- More frequent and substantial feedback is given to the supervisee
- Greater monitoring of supervisee wellness and potential impairment

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